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Comments and Feedback

This Consultation Draft of Primary Health Tasmania’s Mental Health Commissioning Intentions 2016-2017 provides a high level overview of mental health services in Tasmania through a primary health lens.

We are of the view that the bulk of this information has not been previously collated in a document of this nature and as such poses as many questions as it provides answers.

The recently completed State Government led Rethink Mental Health Plan presents the current views of the broad mental health sector in Tasmania. From a primary mental health care perspective we believe our role is to validate this work and to this end seek your feedback in relation to the intentions in this document to ascertain the following:

- Does Primary Health Tasmania need to extend the scope and extent of stakeholder engagement, if so who with?
- What priority or further validation might be required with regard to the information and intentions made in the Consultation Draft document?
- Are there any gaps or issues that have not been adequately captured that could or should be considered?
- What are the priority primary mental health care outcomes for Tasmania?

Written feedback

Submissions in the form of comment and feedback can be sent to Primary Health Tasmania by 31 March 2016 to:

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p: Mental Health Commissioning
Primary Health Tasmania
Mental Health Commissioning Intentions
PO Box 2086
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1 Executive Summary

The current alignment of national and state policy directions coupled with strong provider and consumer appetite for mental health sector reform gives us an unprecedented opportunity in Tasmania to achieve real and sustainable change and improved mental health outcomes.

We also have the unique benefits and opportunities that only a single Primary Health Network (PHN) boundary and a single statewide health system can provide.

This represents an exciting opportunity for Primary Health Tasmania, the Tasmanian Government and our key partners and members to work together to deliver a joined-up mental health system for all Tasmanians.

Along with the Australian Government response to the national review of mental health programs and services and the Tasmanian Government Rethink Mental Health Plan, this Primary Health Tasmania Mental Health Commissioning Intentions paper provides key building blocks on which a revitalised Tasmanian mental health service system can be founded.

The commissioning intentions presented in this document are based on the collation, review and analysis of a broad range of primary and acute mental health sector data and information. The key objective is to maintain and strengthen where things are going well and to help clarify and address the issues, barriers, gaps and needs identified within the current primary mental health landscape. It is Primary Health Tasmania’s view that such a comprehensive review has not been conducted previously and that this document may represent the first time that this data and information has been consolidated in one publication.

The data that has been gathered provides a ‘helicopter view’ of the current Tasmanian primary mental health landscape and its analysis has led to more questions rather than clear answers. More detailed analysis needs to be done that considers the relational nature of the different data sets to allow us to better understand where addressable issues exist and what might be done to deliver the best response.

With this caveat in mind Primary Health Tasmania presents the following key commissioning intentions for the period to June 2017. From these intentions activity plans will be developed in collaboration with stakeholders that will support and drive system changes to improve the mental health outcomes of Tasmanians.
Primary Health Tasmania Commissioning Intentions:

1. Work with relevant stakeholders to co-design at least two commissioned services for pilot in 2016-17 to address issues, barriers, gaps and needs identified within the current primary mental health landscape.

2. Initiate and undertake a process that adopts a “commissioning-like” approach in sub-contracting all other primary mental health services for which funding is provided in 2016-17. (A “commissioning-like” approach will involve competitive testing of the market, the development and management of performance indicators and clinical quality indicators that reflect commissioning intent. This is seen as one of the key tools in developing sector readiness for full commissioning.)

3. Work with key partners and stakeholders to develop a Joint Mental Health Commissioning Strategy for primary mental health services in Tasmania which is underpinned by the Australian Government Response to Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services, the Tasmanian Government Rethink Mental Health Plan, the Primary Health Tasmania Comprehensive Needs Assessment, and other relevant stakeholder plans and strategies.


5. Informed by the Joint Mental Health Commissioning Strategy and stepped model of primary mental health care, initiate co-design processes to establish primary mental health service solutions in the areas of:
   a. suicide prevention
   b. low intensity services for people with mild mental illness
   c. child and youth mental health
   d. community-based step-up, step-down models of care for people with severe and complex mental illness
   e. integrated mental health service options to better support the Aboriginal and Torres Strait Islander population.
2 Introduction

This document aims to provide the mental health sector – including consumers, carers, service providers and government – with a high-level insight into the commissioning intentions of Primary Health Tasmania in light of current policy direction and recent reform announcements. These commissioning intentions will be validated in collaboration with all key stakeholder groups, through a comprehensive consultation process.

Primary Health Tasmania and our key partners recognise that the drivers for change are an acknowledgement of a complex and fragmented mental health landscape that requires large scale reform. To achieve this reform there is a clear need to take a considered and consultative approach to the commissioning and co-commissioning of mental health services. This will require courage and the application of a long term vision and commitment to improving mental health services in Tasmania.

At the centre of this reform is a commitment from Primary Health Tasmania to work closely with our partners to ensure that consultation and inclusiveness is the basis of our way of working.

As part of our commissioning strategy and intent we have embarked on a comprehensive sector engagement initiative which, although set within a challenging timeline, will ensure a shared vision and a commitment to joint decision-making. Preliminary consultation has already been initiated with some stakeholders and we plan further engagement with:

- the Australian and Tasmanian governments
- the Australian Government Department of Health, Australian Government Department of Social Services, Tasmanian Department of Health and Human Services, and Tasmanian Health Service
- GPs and other private providers
- the Mental Health Council of Tasmania and its member organisations, including consumer and advocacy representatives
- Primary Health Tasmania’s clinical and community advisory councils
- the broader Tasmanian community, including local government.

Primary Health Networks (PHNs) are also required to undertake a comprehensive needs assessment (CNA) as a core contractual requirement. The CNA is foundational to the establishment of Primary Health Tasmania’s commissioning role and will inform the prioritisation and planning of activities across the organisation. Importantly, the CNA will provide the framework for identifying the health outcomes required from commissioned services. Critical success factors in achieving these outcomes are system integration, professional provider interactions and consumer and community engagement.

The CNA and this Commissioning Intent document provide some early insight into the Tasmanian mental health system in a number of areas including:

- workforce and market capability
- service pathways and flow
- consumers and the local community
- service landscape and demographics
- health status and co-morbidity.
Government priorities 2016-2017

The Australian Government has set a four-year incremental timeline for the implementation of its response to the Mental Health Commission’s national review of mental health programs and services aimed at achieving sustained and systemic reform. As previously discussed there is considerable alignment between these and the actions and intentions outlined in the Tasmanian Government’s Rethink Mental Health Plan in the short and medium term. These are summarised as follows:

2015–16

- Mental health program consolidation commences, with funded organisations given indications of program or funding stream future.
- PHNs are expected to commence commissioning mental health programs.
- PHN sites will be selected for piloting of stepped care approach.
- Work with stakeholders to define the role and scope of public mental health services, community sector organisations, primary health and the private sector and the role they play in an integrated Tasmanian mental health system.
- Work with Primary Health Tasmania to identify relationships between key mental health providers and primary care providers (including GPs) and increase understanding of the spectrum of mental health service provision.
- Improve links between general health (including primary health) and mental health services to address holistic health needs of people with co-morbidities

2016–17

- Digital mental health gateway established.
- PHNs to lead regional planning and integration for mental health services including suicide support.
- Demonstration sites will begin trialing stepped models of care.
- Models of low intensity services developed for people with mild mental illness.
- New approaches to supporting young people with mental health illness implemented.
- Trialing of integrated approaches to Aboriginal and Torres Strait Islander mental health through PHNs.
- Approaches to innovative funding for people with severe and complex mental illness through ‘opt-in’ arrangements.
- Engage with the Tasmanian Government, mental health providers and primary care providers to enhance integration and information-sharing, and provide support to improve GP capability for mental health assessment and treatment. This will ensure a holistic approach to the physical and mental health needs of consumers.
- Better integrate key parts of the mental health system including public mental health services, primary health care, clinical and non-clinical services, and private providers.
- Develop a ‘no wrong door’ approach to improve access to services through improved collaboration and integration of services.
Stakeholder engagement and shared governance

Successful commissioning is dependent upon the commitment of all stakeholders to communicate openly in reaching an agreed understanding of the current health state, the desired health outcomes and the optimal service options that might bridge any identified gap.

Primary Health Tasmania is building on a history of engagement with the mental health sector and community to establish a collaborative environment where shared efforts will be directed toward achieving integrated, whole-of-system mental health service solutions.

Primary Health Tasmania is developing a stakeholder engagement strategy to ensure that simple and consistent two-way communication processes are in place. A key element of this strategy will be a focus on interaction with those with lived experience of mental illness and their carers.

A key element of the Primary Health Tasmania stakeholder engagement strategy will be a focus on interaction with those with lived experience of mental illness and their carers.

Primary Health Tasmania has been involved with, and privy to, the comprehensive stakeholder and community engagement conducted through the Tasmanian Government Rethink Mental Health Plan process. As this engagement process occurred over the last 18 months, the information and feedback collected are still contemporary. Primary Health Tasmania has used the Rethink Mental Health Plan consultation and engagement findings and recommendations as a key source to inform our initial commissioning intentions.

To ensure appropriate shared governance of the mental health commissioning process, Primary Health Tasmania has access to broad health sector advice via its Board, Clinical Advisory Council and Community
National reform policy

The establishment of Primary Health Networks

Primary Health Tasmania is one of 31 Primary Health Networks (PHNs) across Australia. These organisations were established on 1 July 2015 to increase the efficiency and effectiveness of primary health services for patients, particularly those at risk of poor health outcomes, and to improve the coordination of care to ensure patients receive the right care in the right place at the right time. The key priority areas set by the Australian Government for PHNs to target their work are mental health, Aboriginal and Torres Strait Islander health, population health, health workforce, eHealth and aged care. The key mechanism by which the PHNs will achieve these key performance indicators is by being secondary commissioners of health services.

A commissioning approach to health service design is not in itself a guarantee of success but rather a mechanism by which change can be levered. It is widely recognised that this change is no longer optional and the momentum of collective agreement and appetite for reform has never been stronger. These factors culminate in an unprecedented opportunity to improve mental health services in Tasmania.

This commissioning approach aims to deliver improved health service integration by holding providers to account for the delivery of patient health outcomes and simplifying patient access to the right care at the right time. Commissioning is also a mechanism to support better health cost efficiency by refocusing the flow of funds within the health system. Partnerships are necessary as a means to achieve shared health outcomes rather than individual service outputs. Clinical commissioning has been the instrument of choice for the funding of health services in a number of countries including the United Kingdom for over a decade.

In order to ensure we take a commissioning approach that is right for Tasmania, Primary Health Tasmania is committed to the following for locally sustainable commissioning of health services:

- understand the Tasmanian environment
- define issues to be addressed
- establish realistic delivery expectations
- design effective service intervention
- ensure the highest quality services
- continuous engagement
- stepped models of care.

These principles will be supported by quality health intelligence, data and economics, sound financial management and on-the-ground support.

Advisory Council. Primary Health Tasmania is in the process of forming a Primary Mental Health Commissioning Stakeholder Advisory Group to provide mental health-related advice. Membership will include representation from the Tasmanian Government Department of Health and Human Services (DHHS), Tasmanian Health Service (THS), GPs, Mental Health Council of Tasmania (MHCT – non-government and community sector organisations including consumer and carer representatives), private mental health allied and specialist providers, and the National Disability Insurance Scheme (NDIS).
National review of mental health programs and services

The National Mental Health Commission’s 2014 report of the national review of mental health programs and services – ‘Contributing Lives, Thriving Communities’ – made a range of recommendations that have resulted in a significant shift in mental health services policy direction. Its findings painted a picture of a complex system that in its current form, and for a range of reasons including its structural design, is unable to provide the appropriate and sustainable mental health care that people need. The report made a number of key recommendations underpinned by three components:

- person-centred design principles
- a new system architecture
- shifting funding to more efficient and effective ‘upstream’ services and supports.

The Australian Government’s response to the Commission’s recommendations was released in November 2015 announcing a significant role for the PHNs in the commissioning of mental health services, with some program funding redirected to PHNs from 1 July 2016. The announcement outlined a flexible funding pool of $350 million per year to commission local services, with the role of PHNs increasing over time to commission all regionally delivered, Commonwealth-funded primary mental health and suicide services. These announcements did not commit any new funding, but rather redirected existing funds. The Government’s response outlined nine areas of reform:

- locally planned and commissioned mental health services through PHNs, and the establishment of a mental health flexible funding pool
- digital mental health gateway
- refocussing primary mental health care programs and services to support a stepped care model
- joined-up support for child mental health
- an integrated and equitable approach to youth mental health
- integrating Aboriginal and Torres Strait people’s mental health and social and emotional wellbeing services
- a renewed approach to suicide prevention
- improving services and coordination of care for people with severe and complex mental illness
- national leadership on mental health reform.

In the area of drug and alcohol services the Australian Government has committed $300 million as part of its response to the National Ice Taskforce report, $241 million of which will be commissioned through the PHNs for the delivery of further treatment services. PHN commissioning of drug and alcohol services will commence from 1 July 2017.

Primary Health Tasmania will endeavour to take an integrated approach to the commissioning of mental health, suicide prevention and drug and alcohol services. We will work with our partners, consumers and carers to ensure that within the scope of our remit and available information a commissioning approach is implemented that is person-centred and highly inclusive, delivers improved health outcomes, and represents value for money.
Tasmanian mental health and wellbeing policy reform

In October 2015 the Tasmanian Government released ‘Rethink Mental Health - Better Mental Health and Wellbeing: A Long-Term Plan for Mental Health in Tasmania 2015-2025’. The basis for the document was the Rethink Mental Health Project, commissioned by the Tasmanian Government to undertake an independent analysis of Tasmania’s mental health services across state and federal, public and private jurisdictions. Extensive stakeholder consultation was undertaken as part of this project and its findings, recommendations and suggested areas for action showed close alignment with the Mental Health Commission Report and the Australian Government’s response, including:

- establishing a single, statewide public mental health system
- establishing a peer workforce, identified as a way of improving consumer and carer experiences
- using early referral pathways, especially following a suicide attempt or self-harm
- building stronger mental health services for infants, children, young people and their families and carers
- developing stepped models of mental health support in the community
- supporting primary health to be the ‘front end’ of mental health care in Tasmania
- creating a joint workforce development strategy aiming to improve integration with the private mental health sector.

Work will be undertaken to identify a possible opportunity to select one or two of these key directions to focus on as part of an initial commissioning process, and the mechanisms to co-design solutions will become more apparent as the primary work of developing an agreed commissioning strategy matures in the coming weeks and months.

Synthesis of the key recent Tasmanian and national recommendations for the reform of mental health services agrees on the following mental health outcomes:

- consumer self-determination, choice and control
- person-centred and consultative service design
- improved quality of life and sense of belonging
- a joined-up service that provides help at the right time
- reducing the stigma associated with mental ill-health

Through the comprehensive Tasmanian Rethink Mental Health Plan stakeholder engagement process a number of key directions for reform were identified that correlate significantly with the expectations of the Australian Government in its review of mental health programs and services.
3 PHN Role and Partnerships for System Change

The call for system reform and the reasons the status quo is not an option are perhaps best articulated by the Mental Health Commission’s observations that include an estimated economic cost of mental ill-health of up to $40 billion, annual Commonwealth expenditure in excess of $9.6 billion, and the staggering estimate that less than half of people with a 12 month mental health disorder received an intervention for that illness. Conversely, more than half of those who experience a mental illness are therefore not accessing treatment. The Commission also highlighted widespread inequities and its recommendations to address these are reflected in some of the priorities areas set up by the Australian Government’s response, including Aboriginal and Torres Strait Islander mental health.

Fundamental to improving health outcomes and reducing hospital demand is improving the coordination of care for people living with a mental illness through making the best use of the existing system skills and resources. Within Tasmania, significant opportunities exist to achieve this through working more effectively on a whole-of-system approach to improving the prevention and management of mental health. The Tasmanian Government Rethink Mental Health Plan (2015-2025), coupled with the Australian Government’s current national move towards a commissioning approach and a strong level of provider and consumer readiness for change, provide a strong catalyst for this whole-of-system approach.

Recent reforms in Tasmania, including the establishment of a statewide local hospital network (Tasmanian Health Service), a single State Government system purchaser of health services (Tasmanian Department of Health and Human Services), and a single Primary Health Network for the state have readied these key health organisations to approach health reform as strategic system partners. This shared commitment, combined with a well-established network of providers from across the community sector, aged services, local government and private sectors, means Tasmania is ideally positioned to reconfigure the model of care for people at risk of or living with a mental health illness.

Through the comprehensive work and stakeholder engagement already undertaken in the development of the Tasmanian Rethink Mental Health Plan and the subsequent work being progressed by Primary Health Tasmania, we are developing a stronger understanding of the positive and negative experiences of those receiving and providing mental health support and services. This information and understanding will enable a cooperative approach to better plan and design services and mechanisms to support people’s transfer of care across the system. The learnings from this work are well-placed to inform moving to the next stage that will facilitate the system to deliver more targeted and responsive care through the described stepped models of mental health care management.

As system partners, Primary Health Tasmania, the Tasmanian Department of Health and Human Services, the Tasmanian Health Service, the National Disability Insurance Scheme, and provider and consumer/carer representative bodies are well-equipped, have demonstrated performance, and have a shared commitment to taking the next steps to improve system integration and establishing stepped models of mental health support in the community.
**Introduction to stepped models of care**

“Stepped care recovery models aim to treat service users at the lowest appropriate service tier, only stepping up to more specialised services as clinically required.”

Stepped care models make better use of available resources, keeping interventions to a minimum through the use of a sound evidence base for the treatment of various conditions by the right person at the right time and in the right place. A key recommendation in the Mental Health Commission’s report is the fundamental redesign of the system architecture that underpins person-centred care, and key in this new architecture are stepped models of care.

Primary Health Tasmania will work closely with its system partners both in Tasmania and other PHN jurisdictions to develop a functional stepped care model suitable to Tasmanians’ needs. To assist with this work, Primary Health Tasmania is undertaking a body of work to gather the available evidence-based models for mental health care. For example, stakeholders describe a need for case management and supported accommodation. We need to understand if this is supported by the evidence and, if so, what are the key components of success and the commissionable measures of success. This information will be essential to assess both current market capacity and capability and for commissioning services into the future.

The Australian Government has provided a National Mental Health Framework that sets out the principles for a person-centred system within a stepped care service model for people with varying levels of mental health need. Therefore we need to map evidence-based models of mental health care against this framework. This evidence will inform any service design or co-design that is undertaken as part of the commissioning cycle.

Evidence has shown that system improvement is not achieved through the establishment of new service models alone, but requires investment in the systems, workforce capability and interactions and consumer engagement. Critical enablers for implementation of a stepped model of mental health care will be:

- provider role delineation and capability
- scalable and agile models of care
- consistent and well understood pathways of care with structured and defined transition points and processes
- multi-disciplinary and collaborative approaches
- resources and structural enablers
- person-centred approaches to care.

Under a commissioning model, embedding these enablers could be achieved through a dual focus on:

- ‘wrap-around’ investment to be contributed by commissioning partners, along with
- building quality and performance indicators for commissioned providers.

The applicability and scalability of stepped models of care across all chronic conditions including mental health is now established and could be recommended by the Primary Health Care Advisory Group (PHCAG) in its report to the Australian Government. This advisory group has been tasked with examining opportunities for reform of primary health care to improve the management of people with complex and chronic conditions. Primary Health Tasmania believes that the application of stepped models of care for all chronic conditions provides a solid platform for sustainable reform, and advised this in our discussions with and submission to the advisory group. This report is now with the Australian Government and we await its release.
The Australian Government invests in a range of programs that offer primary mental health care including Better Access, Access to Allied Psychological Services (ATAPS), Mental Health in Rural and Remote Areas (MHSRRA), Headspace and Mental Health Nurse Initiative (MHNIP). The Mental Health Commission concluded that the design of these programs is inflexible and that a one size fits all approach may not be making the best use of available resources including the current workforce. The opportunity to divest this program funding into a single flexible funding pool has been discussed by the Government, but the importance of service continuity and sector stability has also been articulated, so there will be a gradual and considered process.

Certainty and stability in the mental health sector are critical to ensure service continuity and access while a considered commissioning approach is developed. The Australian Government response to the Mental Health Commission’s review provides a timeline for the restructure of various programs.

Primary Health Tasmania has submitted an expression of interest to the Australian Government to be a lead site for the development and rollout of a stepped mental health approach. We expect announcement of the successful sites will be made by April 2016.
Suicide prevention

Integral to the Australian Government’s announcements in regard to mental health services are its intentions for the commissioning of suicide prevention and drug and alcohol services. The Mental Health Commission’s report highlighted poor coordination of suicide prevention activities and programs as well as a level of duplication between federal and state activities. It also noted that suicide remains the leading cause of death among those aged between 15 and 44. The key priority areas identified by the Australian Government’s response are:

- national leadership and infrastructure
- a planned and systematic regional approach to suicide prevention led by PHNs
- Aboriginal and Torres Strait Islander suicide
- post-discharge follow-up for those who have self-harmed or attempted suicide.

The suicide rate in Tasmania is the second highest in Australia averaging 15.8 per 100,000. Men are three times more likely to die by suicide and the likelihood increases by seven times for those unemployed and those separated. The Report to the Tasmanian Suicide Prevention Committee in 2014 was commissioned by the Tasmanian Government to inform its suicide prevention strategy. This document makes a range of recommendations including:

- establish a suicide register and focus prevention activities across the lifespan
- carefully monitor suicide rates among Indigenous Tasmanians
- consider unemployment and separation as a serious risk factor
- restrict access to poisons.

These recommendations and the five-year Youth Suicide Prevention Plan for Tasmania currently under development provides Primary Health Tasmania and its partners with an immense opportunity for collaboration and innovation to reach locally relevant solutions.

The Australian Government funds the following National Suicide Prevention Projects:
- Hope for Life
- StandBy Response Service
- Lifeforce Suicide Prevention
- Mates in Construction
- Real Engagement and Linking for men in Construction
- MindOUT!
- MindFrame Education and Training Projects
- Stigma Watch and Media Centre
- Community Broadcasting Suicide Prevention Project
- National Centre of Excellence in Suicide Prevention
- RUOK (Are you ok)
- ReachOUT!Pro
- Strategic Partnership
- LIFE Communications
- Mental Health First Aid

In addition to these national programs there are three programs funded by the Australian Government for the prevention of suicide in Tasmania:
- Rural Alive and Well
- Workplace Training and Education
- Phoenix Centre SP Project.

The Tasmanian Government also funds a range of programs and support initiatives.
4 Mental health in Australia

Prevalence

Almost half (45%) of Australians aged 16-85 years will experience a mental disorder at some time in their life. In the previous 12 months, 20% had experienced a common mental disorder.\(^2\) Of these self-reported conditions, anxiety disorders (panic disorder, agoraphobia, social phobia, generalised anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder) were the most prevalent (14.4%), followed by affective disorders (6.2%) (depressive, dysthymia and bipolar disorder) and substance use disorders (5.1%) (alcohol harmful use (abuse), alcohol dependence, drug use disorders).\(^2\)

Self-reported prevalence of mental health disorders in Australian adults

In 2011-12, the proportion of Tasmanian adults who self-reported a mental health problem at some time in the past was 15%. This was not statistically significantly different to any other jurisdiction with the exception of the Northern Territory (10.6%). The proportion of people who reported high to very high levels of psychological distress (using the Kessler Psychological Distress Scale) in the four weeks prior to the survey (8.9%) were also not statistically significantly higher than in other states.\(^1^4\)

It is estimated that 0.5% of people in Australia have a psychotic illness and are in contact with public specialised mental health services each year. Schizophrenia accounted for 47% of diagnoses among 4-17 year olds.\(^2^2\)

One in four adults experience more than one class of mental disorder. Affective disorder and anxiety disorders were the most common combination followed by anxiety and substance use disorders.\(^2^2\)

One third of people with 12-month mental disorders had a comorbid physical condition (diabetes, asthma, coronary heart disease, stroke, cancer and arthritis). This rate is similar to the general population.\(^2^2\)
However, those with psychotic disorders have disease rates that are higher than in the general population. The most common co-morbidities in people living with a psychotic illness are: heart or circulatory conditions (27% compared with 16% in the general population), severe headaches/migraines (25% compared with 9% in the general population), diabetes (21% compared with 6% in the general population) and epilepsy (7% compared with 0.8% in the general population). This population also has higher rates of morbidity and mortality, often attributed to their physical co-morbidities. People with organic disorders in Tasmania have the highest reported number of co-morbidities (average of 5.4 co-existing conditions).

**Common co-morbidities in those with psychotic disorders compared to the general population**

![Bar chart showing common co-morbidities](image)

Nationally, in the previous 12 months, 14% of children and adolescents were assessed as having a mental health disorder. These included anxiety disorders (social phobia, separation anxiety disorder, generalised anxiety disorder, obsessive compulsive disorder), major depressive disorder, attention deficit hyperactivity disorder (ADHD), and conduct disorder. ADHD was the most common (7.4%), followed by anxiety disorder (6.9%), major depressive disorder (2.8%) and conduct disorder (2.1%). Almost one third (4% of all 4-17 year olds) had two or more disorders at some time in the previous 12 months. Males (16%) were more likely than females (12%) to have experienced a mental disorder.

**Self-reported prevalence of mental health disorders in Australian children and adolescents**

![Bar chart showing prevalence](image)
Despite differences in methodology between the first and second Young Minds Matter surveys:

- the prevalence of depression increased from 2 to 3%
- ADHD decreased from 10 to 8%
- conduct disorder decreased from 3 to 2%.

It is estimated that 2-3% of the Australian population have a severe, 4-6% have a moderate and 9-12% have a mild mental health disorder where severity is judged by diagnosis, intensity and duration of symptoms and degree of disability. For Tasmania, this translates to 15,498 people living with severe, 30,996 people with moderate and 61,992 people with a mild mental health disorder.

The impact of mental ill-health

In Australia, mental and behavioural disorders contribute 13% of the total burden of disease, fourth behind cancer (16%), musculoskeletal disorders (15%), and cardiovascular circulatory disease (14%). Mental illness affects individuals, their families and the wider community. Social problems commonly associated with mental illness include poverty, unemployment or reduced productivity, and homelessness. People often experience social isolation, discrimination and stigma.

In 2013, mental disorders were responsible for 597 deaths, excluding suicide and dementia. Most deaths were due to substance abuse, particularly alcohol. Suicide accounts for 1.7% of all deaths in Australia. In 2013, a total of 2,522 deaths (10.9 per 100,000) were due to suicide. Suicide rates peaked in 1963 (17.5 per 100,000), declining to 11.3 per 100,000 in 1984 and climbing back to 14.6 in 1997. Rates have continued to decline since 1997.

In recent years (2009-2013), Tasmania has had the second highest rate of suicide (14.0 per 100,000) behind the Northern Territory (17.6 per 100,000). Male suicide is more common than female.

Attempted suicide: Suicidality is common and includes suicidal ideation, suicide plans and suicide attempts, 13.3% of Australians aged 16-85 years will experience suicidality at some point in their life. Attempted suicide is more common in females whereas completed suicide is more common in males.

The economic impact of mental ill-health

As previously noted, the cost of mental ill-health to the Australian people is large and estimated to reach $40 billion in direct and indirect costs inclusive of lost productivity. If OECD estimates are used, this figure reaches $60 billion (4% of GDP). Australian Government investment in mental health is as follows:

$9.6 billion:

- 48.8% Disability Support Pension $4,676 million
- 10.7% National agreements $1,024 million
- 10.4% Carer Payment and Allowance $999.1 million
- 9.5% Medicare Benefits Schedule (MBS) $907.9 million
- 8% Pharmaceutical Benefits Scheme (PBS) $768.1 million
- 12.5% other programs $1,200 million
The cost of mental ill-health to the Australian people is estimated to reach $40 billion in direct and indirect costs inclusive of lost productivity. If a 4% of GDP estimate is used as suggested by OECD this figure reaches $60 billion. Actual expenditure in Australia is $9.6 billion.

5 Mental health in Tasmania

The Tasmanian Government’s overall investment in mental health services is more than $114 million, of which approximately $17 million is provided to community sector organisations to provide mental health and drug and alcohol program and services. The remaining $97 million or 85% is spent on public mental health services. The Tasmanian Department of Education also employs a sizeable work force of psychologists and social workers.

The Tasmanian Department of Health and Human Services commissions the Tasmanian Health Service for the provision of mental health services in Tasmania. Community mental health services are delivered in each region (north west, north and south) through a range of adult, child and adolescent, forensic and drug and alcohol services, and older persons services. In addition, the Department funds a range of residential and other support services through non-government organisations and community sector organisations.

The Tasmanian Department of Health and Human Services Mental Health Services provides specialist clinical mental health services across the state targeted at the estimated 3% of the Tasmanian community (14,860 people) with severe mental illness. These services are primarily focussed on secondary and tertiary level care for people with serious mental disorders.34
In Tasmania, there are five psychiatric units in public acute hospitals (131 beds). These include:

- Northside Mental Health Clinic (20 beds at the Launceston General Hospital)
- Spencer Clinic (19 beds at the North West Regional Hospital)
- Department of Psychological Medicine (38 beds at the Royal Hobart Hospital)
- specialist extended treatment services located in the south provide statewide services:
  - Millbrook Rise Centre (27 beds)
  - Roy Fagan Centre (42 beds)
  - Mistral Place (10 beds)
  - Tolosa Street Units (12 beds).

Private hospitals specialising in mental health services in Tasmania are:

- Rivendell Clinic at the North West Private Hospital – 26-bed non-acute inpatient unit treating mood and borderline personality disorders, anxiety, post-natal, psychotic (non acute), stress
- St Helens Private Hospital, Hobart – private mental health facility with 31 bed inpatient unit, general day patient program, specialist outpatient programs
- The Hobart Clinic – 27-bed private mental health service offering a range of programs for anxiety, depression and mood disorders, alcohol and drugs, older persons mental health, memory clinic, recovery groups, family and carer support
- Murray Street Clinic, Hobart – outpatient programs for anxiety, depression, alcohol and drug addictions and stress management
- Calvary Inpatient Mental Health Unit and Day Therapy Services, Launceston – sole private mental health facility in the north of Tasmania offering individualised and specialised programs focused on support, education, understanding, skill development and self-management for those experiencing conditions such as anxiety, depression, panic, obsessive compulsion, psychiatric disorders, substance issues with mental illness and medication adjustments that meet the admission criteria.

There are also inpatient Forensic Mental Health Services (Wilfred Lopes Centre, 23 beds) and Community Forensic Mental Health Services.

Private practising psychiatrists are predominantly located in the southern region. Eighteen of the 25 practising in the state are based in the greater Hobart area.

<table>
<thead>
<tr>
<th>Region</th>
<th>Private psychiatrists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hobart</td>
<td>18</td>
</tr>
<tr>
<td>Launceston</td>
<td>5</td>
</tr>
<tr>
<td>Burnie</td>
<td>2</td>
</tr>
</tbody>
</table>
In Tasmanian public hospitals, mental health disorders are a large contributor to admissions and length of stay. Mental health problems account for approximately 5% of all public and private hospital admissions. (Nationally the figure is 3% (Australian Institute of Health and Welfare (AIHW)). Mood disorders are responsible for the majority (46%) of hospital admissions (private and public). Age-standardised hospital admission rates for mental health problems have been rising significantly in Tasmania since 2008. Nationally the trends have been stable.15

Hospital admission (public and private) by mental health diagnosis

Between the 2008-09 and 2012-13 financial years, hospital admission rates for mental health problems in Tasmania were statistically higher than the national figures. In Tasmania the average increase was 2.4% per year, compared with the national average increase of only 0.1% per year. This equates to just over 10,000 admissions in Tasmania in 2012-13.31

- Mental health problems account for 5% of all hospital admissions in Tasmania and 3% nationally.
- Hospital admission rates for mental health problems have been rising significantly in Tasmania since 2008. Nationally the trends have been stable
The top 500 presenters to public hospitals in 2014 are summarised by ICD-10 level 3 diagnosis in the chart above. Circle sizes represent the number of bed days. The x-axis is the total number of admissions and the y-axis the average length of stay (LOS). Orange circles represent mental diseases and disorders. As can be seen from the graph, mental disorders represent a significant burden on public hospitals.

Of Tasmania’s top 500 presentations to public hospitals in 2014, those with mental diseases and disorders represent a significant burden on public hospitals in terms of bed day utilisation, length of stay and number of admissions.
There is significant regional variation in inpatient service provision and cost:

- Of all hospital admissions, 76% are in southern Tasmania, 13% in the north west and 11% in the north. A review of residential postcode indicates that people are not moving out of their catchment areas to be treated.
- There is no difference between Tasmania and Australia for average length of stay, but the north west has a 23% higher average length of stay and more costly inpatient services (72% higher than national average versus 6% higher in the south and 11% higher in the north). Expenditure on community services sits in the mid-range of the jurisdictions.

The Chief Psychiatrist’s Annual Report 2013-14 indicates that despite fewer inpatient beds (25 per 100,000 population versus 30 per 100,000 nationally), the occupancy rate for inpatient beds across the state is below 85% as recommended above, and the average length of stay across all inpatient units is below the national average.31

- There is significant regional variation between inpatient average length of stay and cost in Tasmania
- Tasmania has the lowest rates of pre (12% vs 41% nationally) and post-admission (21% vs 61% nationally) community care

Tasmania is also below the national average 28-day readmission rates (12.5% versus 14% nationally). Effective pre and post-admission community care is important for reducing hospitalisations and readmissions. Tasmania has the lowest rates of pre (12% versus 41% nationally) and post-admission (21% versus 61% nationally) community care.15

Note that there are no dedicated child and adolescent mental health inpatient units in Tasmania. When admission is necessary, this either occurs on the paediatric wards or they are specialised in the adult mental health unit. A total of 34 children and adolescents were admitted in the financial year 2013-14 across the state to adult mental health units and 179 were admitted with a primary mental health diagnosis to non-mental health inpatient ward.48 Most children are admitted between the ages of 13 and 18. Approximately 24 per 95,500 (0.13%) of children under 15 years of age were admitted to hospital with a primary mental health diagnosis.

Hospital emergency departments (EDs) may be the initial point of care for some people, e.g. for new onset of symptoms, or where after hours care is required. The number of recorded mental health-related ED occasions has increased over time by 5% per year.15 The rate of mental health-related ED occasions of service in Tasmania is similar to the national level of 92 per 10,000 population. There is a difference in age profile for mental health-related presentations (78% are aged 15-54 years old) compared to all ED presentations (51% aged 15-54). Males and females are similarly represented but Aboriginal and Torres Strait Islander people are over-represented (9% versus 6%). The most common principal diagnoses were: neurotic, stress-related and somatoform disorders (28%), mental and behavioural disorders due to psychoactive substance abuse (26%), mood disorders (14%) and schizophrenia and related disorders (12%).15
Looking at ED presentations and hospital admissions from residential aged care facilities for persons aged 65 years and older in Tasmanian public hospitals during 2010-14, mental and behavioural disorders were:

- the sixth most common reasons for a presentation to the ED
- the fourth most common reason for admission
- the second biggest contributor to bed days and average length of stay.

Ambulatory equivalent mental health-related care is comparable to that provided in community mental health care services. They are day cases and do not involve an overnight stay. These account for 0.5% of public hospital admissions. These separations are third highest for those aged 65 years and over; females account for 60% of separations overall but females are markedly over-represented in the 15-24 and 65 years and over age groups. The most common principal diagnoses for those with specialised care were: other anxiety disorders 17% (includes panic, generalised anxiety, mixed anxiety and depressive disorders), eating disorders 15%, and depressive disorders 14%. The most common principal diagnoses for those without specialised care were: alcohol-related 38% and other anxiety disorders 12%. Forty one percent received allied health intervention, 21% alcohol detoxification and 20% assessment.\textsuperscript{25}
Community mental health services

There are three service streams:

- Child and Adolescent Mental Health Services (CAMHS)
- Adult Community Mental Health Services (ACMHS)
- Older Persons Mental Health Services (OPMHS).

Tasmania has the lowest number of service contacts per 1,000 population (293 versus ~375 nationally). Again there appears to be regional variation with higher contacts per client in the north for children and adolescents and older persons.

Crisis Assessment Treatment and Triage (CATT) services are delivered through community mental health services, providing a mental health crisis response including assessment and triage.

The Mental Health Services Helpline is a 24 hour, seven day a week statewide triage service.

Nationally, people aged 35-44 received the greatest number of community mental care contacts, with males being higher than females (386 versus 341 contacts per 1,000 population). Residents in the most disadvantaged areas had the highest rate of contact (473 per 1,000 population).\(^{20}\)

The most frequently recorded principal diagnosis was schizophrenia (23%) followed by depressive disorder (11%) and mental disorder, not otherwise specified (8%). The majority (82%) of service contacts involved individual sessions and 54% of these occurred with the patient present. The average contact duration was 47 minutes in 2013–14. One third were 5–15 minutes.\(^{34}\)
Residential mental health care services provide specialised mental health care on an overnight basis in a domestic environment and include rehabilitation, treatment or extended care. The AIHW reports on government-funded services.

- **Tasmania has the lowest number of community service contacts per 1,000 population** (293 vs 375 nationally).
- **There appears to be regional variation with higher contacts per client for children and adolescents and older persons in the north.**

Tasmania has the highest rate of episodes of care (14.6 per 10,000 versus 3 per 10,000 nationally). Nationally the rate of residential care days was 123 per 10,000 population in 2013-2014, with Tasmania reporting the highest rate (799). Nationally the highest rate of episodes was for people aged 35-44. The most frequently recorded principal diagnoses nationally for residential care episodes is schizophrenia (32%) and depressive episode (12%). Fifty eight percent had a length of stay of two weeks or less.¹⁹

- **Tasmania has almost five times the national rate of episodes of residential mental health care** (14.3 vs 3 per 10,000).
- **Tasmania has more than six times the national average of residential care days** (799 vs 123 per 10,000).
Expenditure on mental health services in Tasmania

Tasmania had the highest state government per capita spending on mental health services in 2010-2011. The state has:

- among highest per capita expenditure by state government on adult services but below national average spending on child and adolescent and older persons mental health services. (Note: in Tasmania, general adult services may care for older persons and children and adolescents)
- the second highest growth in mental health workforce – predominantly allied health, followed by medical practitioners and then nurses
- above national average per capita expenditure on inpatient care
- below national average inpatient beds (25/100,000 population versus 30/100,000)
- above national average cost per patient day ($1,140 versus $842)
- it is the leading provider of 24 hour staffed and non-24 hour staffed residential services. Above national average residential services (adult and older persons beds)
- fewer supported public housing places per 100,000.
- highest total beds (inpatient and community residential) – 58.3/100,000 population versus national average 40.2/100,000
- the lowest rate (293/1,000) of service contacts with community mental health care services provided by state and territory governments. (National rate 374/1,000 population.)
- the most frequently recorded principal diagnoses nationally are schizophrenia (23%) and depressive episode (11%).
- above national average full time equivalent direct care workforce (132/100,000 versus 108/100,000)
- below national average Medicare-subsidised mental health services (6.1% of Tasmanian population saw an MBS-funded provider (psychiatrist, GP, allied health) versus 6.9% nationally
- above average PBS-funded pharmaceuticals ($44 total PBS/RPBS benefits paid per capita versus $38 nationally)
- below national average percentage of mental health consumers living in stable housing (National Mental Health Report 2013). Tasmania has above national average Specialist Homelessness Services clients with a current mental health issue accessing both accommodation (253 versus 138/100,000 nationally) and non-accommodation services (155 versus 108/100,000 nationally).

- Tasmania has among the highest state government per capita expenditure on mental health services.
- The Tasmanian Government’s overall investment in mental health services is more than $114 million, of which approximately $17 million is provided to community sector organisations to provide mental health and drug and alcohol programs and services.
- The remaining $97 million or 85% is spent on public mental health services.
6 Primary Mental Health Services

Community sector organisations – including non-government organisations – deliver a range of mental health services in Tasmania, funded by the Tasmanian and Australian governments. Nationally, the total expenditure administered by the Australian Government Department of Health, the Australian Government Department of Social Services and the Australian Government Department of Prime Minister and Cabinet is $606 million (2012-13). In total these departments administered 64 programs totaling $606 million allocated to 542 organisations. The largest grant of $69.4 million went to Headspace and $29.5 million to Beyond Blue. The Australian Government Department of Veterans’ Affairs also provided $167 million (2013-14) for mental health programs that provide advice and assistance to veterans and their families.

Further work is required to fully understand the program types, services scope, performance measures and funding levels across community sector organisations and non-government organisations in Tasmania.

Community sector organisations in Tasmania

The Tasmanian Government provides approximately $17 million in funding to community sector organisations which deliver a range of services including:

- supported accommodation
- residential rehabilitation
- individual packages of care
- community-based recovery and rehabilitation programs
- services for children and families
- peer support groups
- advocacy
- peak body representation for consumers, carers and service providers.

More than 70% ($12.171 million) of this investment is spent on the provision of supported accommodation residential placements and individualised packages of care. These are provided by a range of organisations with variable funding agreements. A summary is provided below.

<table>
<thead>
<tr>
<th>Packages of care</th>
<th>Residential placements (beds)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No.</td>
<td>Investment ($)</td>
</tr>
<tr>
<td>North</td>
<td>98.5</td>
</tr>
<tr>
<td>North west</td>
<td>113</td>
</tr>
<tr>
<td>South</td>
<td>128.5</td>
</tr>
<tr>
<td>Total</td>
<td>340</td>
</tr>
</tbody>
</table>
During 2013-2013 Tasmania had the highest rate of residential mental health care episodes per 10,000 population (20.9) of all state and territories (national average 2.9)\(^{39}\)

<table>
<thead>
<tr>
<th>State</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSW</td>
<td>0.4</td>
</tr>
<tr>
<td>WA</td>
<td>1.1</td>
</tr>
<tr>
<td>SA</td>
<td>10.7</td>
</tr>
<tr>
<td>Qld (does not report any)</td>
<td></td>
</tr>
<tr>
<td>Vic</td>
<td>5.3</td>
</tr>
<tr>
<td>Tas</td>
<td>20.9</td>
</tr>
<tr>
<td>ACT</td>
<td>1.8</td>
</tr>
<tr>
<td>NT</td>
<td>4.2</td>
</tr>
</tbody>
</table>

Australia 2.9

This significant investment is worthy of consideration in light of the development of a stepped model of care that will seek to better define the evidence base for the various interventions that sit under each specific step. There is a tremendous opportunity to improve health outcomes through the application of a consistent evidence base that ensures consistent service delivery.

(a) Medicare Benefits Schedule (MBS)

Nationally, in a 12-month period, 35% of people with a common mental health disorder (1.1 million people) made use of mental health services. Of these: 71% consulted a GP, 38% a psychologist, and 23% a psychiatrist. Of those who did not receive care, 86% reported no perceived need for mental health care. Thus 14% perceived a need and did not access a mental health service.

**Percentage of people with a mental health disorder who made use of mental health services in a 12 month period**

![Bar chart showing percentage of people with mental health disorders who used services](chart)

People with affective disorders were more likely to use services for their mental health problems as were those who had a more severe disorder. Service use was also higher in people with two or more mental disorders, amongst those who had attempted suicide in the previous 12 months (73.4%), and by people who made a suicide plan (68%).\(^{39}\) This indicates that 66-75% of those who need services most are accessing them.
The second National Mental Health Survey showed a doubling of psychologist care and increased levels of met and perceived need suggesting improvements in treatment access or effectiveness and willingness to seek treatment. However, population mental health did not improve. Treatment access also may have improved by 23% (to 46%) between the 2006-07 and 2009-10 financial years, primarily thought to be due to uptake of Better Access services.

- Nationally, in a 12 month period, 35% of people with a common mental health disorder (1.1 million people) made use of mental health services.
- Of the 65% who did not receive care, 86% reported no perceived need for mental health care. Thus 14% perceived a need and did not access a mental health service.

MBS demographics of access

In 2011, 1.5 million people accessed MBS-subsidised mental health-related services. Females and those aged 15-64 years were more likely to access services than others. For both men and women, GPs were the most common service provider (1.2 million services) with 7% of all females and 4% of all males accessing a GP. Psychologists were the next most common (4% females compared with 2.4% males).

Of all people living in the most disadvantaged areas, 6.2% accessed a GP, 2.9% a psychologist, and 1.3% a psychiatrist. In areas of least disadvantage, 5.2% saw a GP, 3.6% a psychologist and 1.7% a psychiatrist. Similarly, people with a bachelor’s degree or higher were more likely to see a clinical psychologist and psychiatrist than people who had ceased their education in Year 11 or below. People who were unemployed or not in the labour force were more likely to access MBS mental health-related services than those who were employed, and the unemployed were more likely to see a psychiatrist.

Access to mental health care by socioeconomic status

[Diagram showing access to mental health care by socioeconomic status, with bars indicating percentages of people accessing services in areas of more and less disadvantage.]
Health-related services provided by general practice

It is important to note that not all mental health-related GP encounters are billed using MBS mental health-specific item numbers, hence numbers are higher than MBS item number usage. Furthermore, billing practices may not reflect the time spent with a patient or the quality of the consultation.

General practice

In 2013-14, 13% of GP encounters were mental health-related (735 encounters per 1,000 population). This represents a significant increase from 11% in 2009-10.

Depression, anxiety and sleep disturbance were the three most frequently managed mental health problems. These accounted for 59% of mental health-related problems and 5% of all health problems managed. The most common form of management by a GP was medication being prescribed, supplied or recommended (62 per 100 mental health-related problems managed). Antidepressants were the most common (26 per 100), followed by anxiolytics (10 per 100) and hypnotics and sedatives (9 per 100).

The second most common form of management by a GP was counselling, advice or other clinical treatments (50 per 100 mental health problems managed) with psychological counselling being the most frequent treatment (24%) in this category. Sixteen referrals were made per 100 mental health problems managed. Psychologists were the most common provider referred to (8 per 100), followed by psychiatrists (2 per 100).

The National Health Performance Authority report into GP care for patients with depression and anxiety (2009-13) demonstrated that care varied across Medicare Local catchment areas as did GP actions in management. This illustrates different management approaches – e.g. in prescribing rates, counselling rates and referrals – which may reflect access and availability of mental health specialists and allied health providers. There were also notable differences between similar local areas within the same peer group, after accounting for geographical and socioeconomic characteristics.¹⁶

The Commonwealth Fund recently released a report which found that 85% of Australian GPs surveyed felt their practices were well prepared to manage patients with multimorbidity. However a major concern is that while 48% felt well prepared to manage palliative care, and 46% patients with dementia, only 34% felt their practices were well prepared to manage patients with mental health problems and only 19% felt capable of managing patients with substance misuse.

Compared to other Regional 2 (R2) Medicare Local catchment areas, Tasmania has the second highest percentage of GP consultations in which depression or anxiety was managed, however confidence levels overlap for all but three out of 15 areas. (Tasmania 8% of GP consultations compared with R2 average of 7%). We can also compare Tasmania to other R2 areas for the percentage of GP management occasions in which psychotropics were prescribed (66% versus the R2 average of 63%), in which GP counselling occurred (28% versus R2 average of 30%), or referrals were made (13% versus R2 average 14%).
• 13% of GP encounters were mental health-related in 2013-14, a significant increase from 11% in 2009-10 (735 encounters per 1,000 population).
• A recent report found that only 34% of general practices felt well prepared to manage patients with mental health problems and only 19% in managing patients with substance misuse.
• Tasmania has below average MBS-subsidised psychiatric mental health services and below average number of psychiatrists per capita.

Mental health plans completed by GPs

Mental health plans provide a structured framework to undertake early intervention, assessment and management of patients with mental disorders, providing referral pathways to other health professionals.

Nationally in 2013-14, there were 965,946 MBS-funded services for mental health plans completed by GPs or 4,260 per 100,000 people. There was considerable variation between local areas, and between states and territories, based on geographic location and levels of socio-economic disadvantage. Tasmania was among the states and territories with rates markedly lower than the national average (4003 per 100,000 people). Nationally, psychologists provided 43% of all MBS-subsidised mental health related services. Interestingly, Tasmania had the highest rate of clinical psychologist services at 96 per 100,000 population but below national average for other psychologists. Clinical psychologists tend to provide psychological assessment and therapy for a mental disorder whereas other psychologists tend to provide focussed psychological strategies, e.g. cognitive behavioural therapy.16

Nationally, psychiatrists provided 25% of all MBS-subsidised mental health related services. Tasmania has below national average MBS-subsidised psychiatrist mental health services per 1000 population12 and below average number of psychiatrists per capita.

Bulk Billing Rates in Tasmania

Bulk billing rates in Tasmania for all services in and out of hospital are slightly below the national average, and have steadily increased over the last 10 years.

<table>
<thead>
<tr>
<th>Bulk billing rates (% of services) in and out of hospital</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>NT</td>
<td>85.4</td>
<td>86.8</td>
</tr>
<tr>
<td>NSW</td>
<td>79.2</td>
<td>79.4</td>
</tr>
<tr>
<td>SA</td>
<td>77.9</td>
<td>78.4</td>
</tr>
<tr>
<td>QLD</td>
<td>77.2</td>
<td>77.5</td>
</tr>
<tr>
<td>VIC</td>
<td>76.6</td>
<td>77.1</td>
</tr>
<tr>
<td>TAS</td>
<td>74.4</td>
<td>74.7</td>
</tr>
<tr>
<td>WA</td>
<td>72.1</td>
<td>73.4</td>
</tr>
<tr>
<td>ACT</td>
<td>65.5</td>
<td>65.9</td>
</tr>
<tr>
<td>Australia</td>
<td><strong>77.2</strong></td>
<td><strong>77.6</strong></td>
</tr>
</tbody>
</table>
(b) Pharmaceutical Benefits Scheme (PBS)

Nationally for the period 2013-14, 12% of all prescriptions dispensed were for mental health-related medications (1,469 prescriptions per 1,000 population).\(^{13}\)

The majority (86%) of mental health-related prescriptions were written by GPs, 8% were prescribed by psychiatrists, and 6% by non-psychiatrist specialists. Sixty seven percent of prescriptions were for antidepressants, 12% for anxiolytics, 11% for antipsychotics, and 8% for hypnotics and sedatives.\(^{13}\)

In 2011, 2.3 million people accessed PBS medications. In 2011, Tasmania had the highest proportion of the population accessing PBS mental health drugs (14.5%). The AIHW cautions that the higher rate of mental health-related prescribing may reflect the older age structure in the state, however the rates published in the *Australian Atlas of Healthcare Variation* have been age standardised.\(^{27}\)

Females were more likely than males to access these drugs (13.3% versus 8.5%). Access increases with increasing age (34% of all people aged 75 years and over access one or more mental health drugs). For females, antidepressants were the most common (10% of all females), followed by anxiolytics (3.1%) and hypnotics and sedatives (2.9%). For males, antidepressants were the most common (5.6% of all men).\(^{12}\)

A social gradient is evident, as follows:

- almost 15% of those with Year 11 or below schooling accessed medication compared with 6.4% with a bachelor’s degree or higher
- 6.6% of all employed Australians 15-64 years compared with 13.3% of unemployed and 20% not in the labour force, accessed medication
- in the most disadvantaged areas, 15.4% of all people accessed a PBS mental health drug, most commonly antidepressants
- of all people living in the least disadvantaged areas, 7.2% accessed a PBS mental health drug.

**PBS data for Tasmania**

Tasmania had a considerably higher rate of prescriptions than the national average (1489 subsidised and 1902 total prescriptions per 1000 population):\(^{13}\)

- the majority 52,785 (10.7%) accessed antidepressants (above the national average of 7.8%)
- 19,256 (3.9%) accessed anxiolytics (above the national average of 2.5%)
- 13,712 (2.8%) accessed hypnotics and sedatives (above the national average of 2.3%)
- 7946 (1.6%) accessed antipsychotics (equal to the national average)
- 1978 (0.4%) accessed psychostimulants, agents used for ADHD and Nootropics (equal to national average).
There is significant variation in dispensing rates for ADHD, anxiety, depression and psychotic disorders in Australia both within and between states and territories and based on levels of socioeconomic disadvantage (2013-14 data). Rates provided below are the mean rate per 100,000 population age standardised for the region.

The recently published Atlas for Healthcare Variation shows Tasmania has the highest dispensing rate for:

- antidepressants in those aged 18-64 years (mean rate 139,004 versus national 101,239)
- anxiolytics in those aged 18-64 years (mean rate 25,802 versus national 17,201)
- anxiolytics (65+ years) (54,247 per 100,000; national average 37,695)
- opioid medicines (73,641 versus national average 55,126).

Tasmania has the second highest dispensing rate for:

- ADHD medicines in those less than 18 years (13,253 per 100,000; national average 10,780)
- antidepressants in those less than 18 years (9608 per 100,000; national average 7989)
- antidepressants (65+ years) (211,950 per 100,000; national average 196,574)
- antipsychotics (18-64 years) (19,616 per 100,000; national average 17,844)

Tasmania was below the national average dispensing rate for:

- antipsychotic medicines in those less than 18 years (1632 per 100,000; national average 2070)
- antipsychotics (65+ years) (22,009 per 100,000; national average 27,043)
- anticholinesterase medicines (65+ years) (5,478 per 100,000; national average 12,650).

Some Tasmanian PBS comparative data is above the national average per 100,000 population, which requires further analysis and understanding.
The Access to Allied Psychological Services (ATAPS) program was established in July 2001 in response to low treatment rates for common mental disorders. Originally delivered through the Divisions of General Practice and then the Medicare Local network, the program is now administered by the Primary Health Networks through a combination of commissioned, sub-contracted and directly delivered services. Funding for the ATAPS program in Tasmania is $2.7 million.

Designed to improve access to mental health services, ATAPS is a complementary program to and precedes available Medicare-based services under the Better Access to Psychiatrists, Psychologists and General Practitioners (Better Outcomes in Mental Health Care (BOiMH)) program, as well as Mental Health in Rural and Remote Areas (MHSRRA) and the Rural Health Outreach Fund (RHOF). The program allows GPs to refer people with low to medium acuity diagnosed mental health disorders for low cost, evidence-based (most commonly cognitive behavioural therapy) services to be delivered in up to 12 sessions (or 18 in exceptional circumstances).

The program is designed in a two tier structure, the first targeting the general population and the latter targeting hard-to-reach groups including Aboriginal and Torres Strait Islander people, women with perinatal depression, those at low to medium low risk of suicide, those experiencing or at high risk of homelessness, and children who have or are at risk of developing a mental health disorder.

A 10 year consolidated evaluation report of the ATAPS program undertaken in 2013 by the University of Melbourne Centre for Mental Health concluded that:\(^{54}\)

- uptake of the program is strong with 277,000 people receiving 1.5 million sessions of care between 2002-12, with an average of 5.2 sessions, and it is an integral part of the primary mental health care system
- majority are women with high prevalence disorders
- tier 1 activities are achieving considerable positive clinical outcomes while tier 2 activities are producing significant clinical improvement.
The ATAPS program in Tasmania is delivered through a combination of commissioned, sub-contracted and directly-delivered services. By 1 July 2016, Primary Health Tasmania will have assessed market capability and capacity for the delivery of ATAPS services in Tasmania in keeping with government expectation that PHNs deliver services directly only in the event of demonstrable market failure. The Australian Government is yet to fully define demonstrable market failure. ATAPS services in Tasmania are delivered in every local government area and are predominantly focused on improving access rates in rural and more remote areas of Tasmania.

Nationally, of the 264.3 ATAPS consumers per 100,000 population, 51% were aged 25-54 years, 67% were female, and 44% had previously used a psychiatric service. The most common referral condition was depression (54%), followed by anxiety disorders (43%).

At a state level, ATAPS uptake has steadily increased over the last four years, however Tasmania had the second lowest ATAPS referral rate (204.5 per 100,000 population) – well below the national average (AIHW). Regional differences are evident – the west and north west region has more than twice the state average of services per 100,000. Between 2003 and 2016 and consistent with national statistics, two thirds were female. Eighty six percent were low income earners, 7.3% identified as Aboriginal or Torres Strait Islander, and 19% lived alone. Of note, only 9% of referrals had both pre and post ‘Depression Anxiety Stress Scales’ (DASS) scores recorded, and this warrants further investigation and analysis.

The statistical differences in ATAPS referral and utilisation from the national average require further analysis and understanding.
(d) Mental Health Services in Rural and Remote Areas (MHSRRA)

The Mental Health Services in Rural and Remote Areas (MHSRRA) program provides funding to non-government organisations to deliver mental health services in rural and remote communities. The program aims to improve access to mental health services where access to Medicare-subsidised mental health services is low. The total funds available for MHSRRA was $125 million for the period 2006-07 to 2012-14. The funding formula used is based on the Australian Standard Geographic Classification – Remoteness Areas (ASGC - RA) System and the accessibility of Medicare-subsidised mental health items. In Tasmania, the program is currently administered by Primary Health Tasmania, and previously Tasmania Medicare Local and North West Tasmania Division of General Practice. The total 2015-16 funding amount for the program in Tasmania is $704,000. Provider eligibility is the same as the ATAPS program with psychologists and credentialed mental health nurses, social workers, occupational therapists and Aboriginal health workers eligible to deliver services. The clinical scope of service delivery is the same as ATAPS and centres around short-term targeted intervention.

(e) Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP)

The Rural Health Outreach Fund (RHOF) and Medical Outreach Indigenous Chronic Disease Program (MOICDP) are funded by the Australian Government and consolidate a number of programs including the Medical Specialist Outreach Assistance Program (MSOAP) and its ophthalmology and maternity services expansions, rural women’s service and the Kimberley Paediatric Outreach Programs. Mental health is one of the four health priority areas under the RHOF.

In Tasmania the RHOF and MOICDP are administered by the Tazreach offices of the Tasmanian Department of Health and Human Services. The total funds spent on mental health outreach services is just over $1 million. These services are delivered throughout Tasmania and are delivered regularly by specialties including:

- psychiatry, including dual disability, alcohol and other drugs (AOD), geriatric, forensic, child and adolescent and general
- psychology, including pain management
- social work
- behavioural management
- mental health nursing.

(f) Mental Health Nurse Initiative Program (MHNIP)

The Mental Health Nurse Initiative Program (MHNIP) began in July 2007 and is administered by the Australian Government Department of Human Services through Medicare. It funds a range of organisations including community-based general practices and private psychiatric practices to employ mental health nurses. The program provides non-MBS incentive payments and aims to coordinate care for patients with severe and persistent mental health conditions.
mental illnesses by monitoring the patient’s mental state, managing their medication and improving links to other health professionals and service providers. The program targets just over half (0.6%) of the 1.2% of people in the community with severe and persistent mental illness. To be eligible, patients need to have been diagnosed with a severe mental health disorder that is significantly impacting their social, personal and work life and either have been or are at risk of hospitalisation. The person is expected to need ongoing treatment and management of their mental disorder over a period of two years and the GP or psychiatrist remains the main person responsible for the patient’s clinical mental health care. Services can be delivered in a range of settings including clinics and the patient’s home. Services are funded on a fixed price per session based on rurality (classified as urban or rural). There are minimum service delivery criteria required per session claimed.

Uptake of the MHNP has been varied across Australia, and there are currently only 10 organisations registered to deliver the initiative in Tasmania – three in the north of the state and seven in the south. Between 1 July 2009 and 30 June 2011, general practices and Medicare Locals (formerly Divisions of General Practice) accounted for 80.9% of services delivered and 76.4% of nurses employed.

In 2012, Health Care Management Advisors were engaged by the Department of Health to evaluate the MHNP, and they made a range of observations and recommendations including:

- variable uptake across organisation types results in a self-selected, demand-driven approach which has resulted in inequitable service delivery, and further investigation of unmet demand
- supply-driven design has meant growth not always linked to geographic areas of relatively higher need
- program guideline revision to clarify roles, responsibilities, services provided and clinical governance including formalised pathways between MHNP and other services.

### Average services per year

![Map showing average services per year](image)
In 2014-15 in Tasmania, 1,000 patients accessed this service. MHNIP services have been steadily decreasing over the last four years. The service usage rate is highest in Launceston and the north east, although this region has also experienced the steepest decline.

Total program funding for the MHNIP is approximately $40 million and the current session allocation for Tasmania for the 2015-16 financial year is almost $600,000. This represents 1.2% of the overall available funding. The geographic location and reach of current eligible organisations may also be worthy of analysis.

The future of the MHNIP is discussed in the Australian Government’s recent review of mental health programs and services and included in its references to the development of new innovative funding to better support coordinated wraparound services for people with complex needs. It adds that the arrangements will also be supported through an enhancement of the MHNIP, including arrangements to address geographic inequities of the scheme. The Australian Government has advised that over the next three years it intends to address the current maldistribution of services, and some modest additional funding will be made available in 2016-17 for PHNs most disadvantaged. There is also reference to the potential for a number of existing programs targeting people with severe mental illness to transition to the National Disability Insurance Scheme over coming years. PHNs have been advised that they will be responsible for the MHNIP program from 1 July 2016, but a transition period of 12 months has been put in place to support current service providers and patients and assure service continuity.

Tasmanian participation rates in the MHNIP are lower than the national average. National review of the distribution and session allocation may assist to improve access.
(g) Partners in Recovery (PIR)

The Partners in Recovery (PIR) program is funded by the Australian Government Department of Health and provides coordinated support and flexible funding for approximately 24,000 people (and their families and carers) with severe and persistent mental illness and complex needs. The objectives of PIR as set out by the funder are:\(^3\)

- facilitating better coordination of clinical and other supports and services
- strengthening partnerships and building better links between providers
- improving referral pathways that facilitate access to services and supports
- promoting a community-based recovery model to underpin all clinical and community support services.

The program was allocated $430 million funding from 2012-13 to 2015-16. There are 48 organisations delivering the initiative with the establishment of a further 13 delayed in the 2014-15 budget for two years. The deferral was documented as “allowing the effectiveness of existing sites and their interaction with the National Disability Insurance Scheme to be assessed”. Urbis has been commissioned to undertake a longitudinal evaluation over a three-year period, 2013-2016.\(^5,6\)

In Tasmania, the lead agency for the program is Anglicare Tasmania, and the consortium members are Colony 47, Relationships Australia, ASPIRE, Richmond Fellowship and Primary Health Tasmania. The 2014-15 PIR Annual Report identifies a number of key challenges for the program and articulates a range of capacities and capabilities among consortia organisations as critical to the program’s success at a local level.\(^5,7\) These include partnership interaction and endurance, staffing, and the complex and changing policy landscape.

From July 2013 to March 2015 there were 12,628 clients registered with PIR organisations, a 141% increase since June 2014. Tasmania had 462 clients registered, representing 4% of the national total.\(^5,6\) Of these clients:

- 67% were aged 25 to 54, with 9% under 25, 12% over 55 and 12% not stated
- more than one third (37%) were living in a lone person household
- 48% had unspecified mental disorders (two to four times above the national average)
- 62% lived in private residences
- 6% were employed
- 63% of clients had affective and schizotypical disorders.

The Australian Government has advised that that PIR and Day to Day Living programs are in scope to transition to the National Disability Insurance Scheme as expansion from current trial sites commences on 1 July 2016, with national coverage by 30 June 2019. Negotiations regarding transition arrangements are underway and as such these programs will not form part of the PHN flexible funding pool.\(^2,8\)

(h) Headspace and Youth Early Psychosis Program (yEPP) (formerly EPICC)

Established in 2006 and managed by the not-for-profit National Youth Mental Health Foundation, the Headspace program provides early intervention mental health services for people aged 12 to 25 years. The program offers support in the areas of mental health, employment, drug and alcohol, relationships and school. GP and psychiatry services offered in this setting are funded through the Better Access Initiative and MBS services.
There are currently 73 fully established Headspace centres across Australia. The Launceston provides outreach services in Devonport. Another five centres are due for completion by the start of 2017. Only 13 centres offer the yEPP program. In 2012-13 the program received total funding of $69.4 million. Tasmania received approximately $2 million. At a national level, 128, 316 young persons received services at Headspace centres with 99, 075 being new young persons (2013-15 calendar years). Of these, 33.8% were aged 15 to 17, 22.7% were 12 to 14, and 23.1% were 21 to 23. There were 704,513 occasions of service averaging 5.4 visits per client. The average wait between first and second visit was 6.77 days. Just under 1,900 (1.48%) reported being at risk of homelessness soon, with a further 11,189 (8.72%) reporting that accommodation was an issue. The delivery of GP and other MBS services varies and is dependent upon the operating model and maturity of the individual centre. Both the Launceston and Hobart Headspace centres provide GP services.

The Australian Government has advised that Headspace funding is transitioning to the PHNs from 1 July 2016, and that the PHNs will be asked to continue with current sites and services for a period of two years. The transitioning arrangements for the existing early psychosis services are also under consultation. The Australian Government commissioned the Social Policy Research Centre (UNSW) to evaluate the Headspace program in 2015. This report has not been released.

### Tasmanian Headspace activity 2014-15

<table>
<thead>
<tr>
<th>Centre</th>
<th>Occasions of service</th>
<th>New young persons</th>
<th>Serviced young persons</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hobart</td>
<td>4321</td>
<td>754</td>
<td>1169</td>
</tr>
<tr>
<td>Launceston</td>
<td>5614</td>
<td>747</td>
<td>3286</td>
</tr>
<tr>
<td>Devonport</td>
<td>722</td>
<td>124</td>
<td>471</td>
</tr>
</tbody>
</table>

**Targeted Community Care Program**

Under the Targeted Community Care Program the Department of Social Services funds three programs providing support to clients and their families/carers to manage the impact of living with a mental health illness. The total allocation for these programs in 2012-13 was $180.8 million. Further investigation and analysis is required to better understand this area of the mental health sector.

**Personal Helpers and Mentors (PHaMs)**

Funded by the Australian Government, this program uses a recovery and strengths-based approach and aims to increase opportunities for recovery for people 16 years and over whose lives are severely impacted by mental illness, by helping to overcome social isolation and increase community connections. Strategies include:

- practical assistance to achieve personal goals
- develop better relationships with family and friends
- manage everyday tasks
- assistance to access services and participate.

Tasmania has one of the lowest numbers of (PHaMs) participants. The most common principal diagnoses were mood disorders (67%), followed by anxiety disorders (40%) and delusional disorders (23%). In Tasmania, PHaMS services are delivered by two non-government organisations.
(j) Psychiatric Disability Support Services

Under the National Disability Agreement, service users with a psychiatric disability as their primary or other significant disability may be provided with non-residential and residential disability support services. Tasmania has below the national average rate of service users (~320 versus 368 per 100,000).

Tasmania has below national average non-residential disability support service use (~310 versus 370 users per 100,000). Of these service groups nationally, employment services had the highest rate of service users. Other categories include accommodation support, community support and respite services. Almost two thirds of users identified psychiatric disability as their primary disability; 55% were male, 67% aged 25-54 years, and 39% lived alone.

Tasmania has above national average use of residential disability support services (~29 versus 16 per 100,000). Group homes were the most common form of accommodation nationally. Psychiatric disability was identified by 71% as their primary disability, 58% were male, and 73% aged 35-64 years.

(k) Mental Health Respite Carer Support (MHRCS)

This program supports the carers of people with mental illness whose own health and wellbeing is impacting on their ability to provide care. It does this through a range of flexible support options. The program aims to increase carer wellbeing, sustainability, confidence and capacity as well as improved social and economic participation. The MHRCS services in Tasmania are delivered by Community Based Support South, Aspire, St Michael’s Association, and Anglicare Tasmania.

(l) Family Mental Health Support Services (FMHSS)

The FMHSS program aims to improve health outcomes for vulnerable children, young people and their families affected by or at risk of mental illness, by providing:

- intensive, long term early intervention
- short term immediate assistance
- community outreach.

FMHSS services in Tasmania are provided by Anglicare Tasmania (three locations), Mental Illness Fellowship of Victoria and Catholic Care Victoria, Tasmania.

(m) Private health funds

Private health funds make up an important component of Australia’s investment in mental health services and the Australian Government’s expenditure on Private Insurance Rebate for mental health related costs was $105 million in 2012-13.55 A small snapshot of national data for the period September 2015 (APRA) shows the total benefits paid by type of Chronic Disease Management Programs in the mental health area as: programs 232, benefits 139,425, fees charges 139,424. In comparison to cardiovascular and diabetes, mental health activity represented only 5% and 11% of total activity respectively. In benefits paid for general treatment (excluding hospital-substitute treatment and Chronic Disease Management Plans) there were 99,619 psych/group therapy services totaling $6,281,260 benefits paid of a total $14,837,377 fees charged.

Further collection and analysis of private insurance activity is required to better understand its contribution to mental health services in Tasmania.
The Tasmanian Department of Education employs a significant workforce invested in the professional support of students and their families and carers. School psychologists undertake assessments, counselling and case management to support concerns including underachievement, poor social coping skills, anxiety, depression and grief. School social workers provide counselling and support to students and their families/carers for issues including relationships, mental health, stress, grief and conflict resolution. \(^{51}\)

As at 30 June 2015 there were 58.04 FTE psychologists and 49.8 FTE special workers employed in Tasmanian government schools. There would be benefit in better understanding the scope and interaction of this workforce within the context of the broader mental health sector. \(^{52}\)

### Mental Health Workforce in Tasmania

Full time equivalent (FTE) employed psychiatrists have declined steadily from 53 in 2010 to 46 in 2013. FTE employed mental health nurses and FTE employed registered psychologists have remained steady over the last three years. In 2013 there were 441 mental health nurses and 348 psychologists (AIHW – National Health Workforce Data Set). The number of employed psychologists per 100,000 population in Tasmania is 78.9/100,000 and 82% of those employed were clinical psychologists. Tasmania has below national average FTE rate per 100,000 psychiatrists (9 versus 13 nationally) and psychologists (65 versus 86 nationally) but above average FTE mental health nurses (85 versus 82). \(^{14}\)

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The map shows the location and number of private psychology practices in the state. Note that any practice employing a psychologist is represented in this map.

<table>
<thead>
<tr>
<th>Region</th>
<th>Private psychologists</th>
</tr>
</thead>
<tbody>
<tr>
<td>South</td>
<td>159</td>
</tr>
<tr>
<td>North</td>
<td>34</td>
</tr>
<tr>
<td>North west</td>
<td>27</td>
</tr>
</tbody>
</table>
Stakeholder consultation undertaken through the Tasmanian Government Department of Health and Human Services: Rethink Mental Health Plan identified that the system lacks governance, an overall strategic vision and leadership. Inconsistent assessment processes and referrals are reflected by an absence of statewide guidelines, policies, procedures and protocols. There was a need expressed for clearly defined scope of practice and role delineation for community mental health, the Crisis Assessment and Treatment Triage (CATT), rehabilitation, step-up, step-down and inpatient services.

Services were described as being poorly integrated, having inadequate transition points around age, diagnosis, services, and levels and not being person-centred. Current services lack a focus on prevention, assessment, early intervention and community-based management. Physical co-morbidities are often not addressed.

Services were described as ‘not fit for purpose’. Cases are becoming increasingly complex and many do not fit within the current service model – e.g. those with personality disorders and drug and alcohol issues or who live in rural areas, such as people with forensic or drug and alcohol issues.

It was felt that mild to moderate cases such as clients suffering a situational crisis overuse acute resources due to a lack of alternative community resources. These could include short-stay or assessment services. Patient support needs to go beyond mental health and include accommodation, relationships, employment, paying bills, transport, etc. Post-discharge from hospital support was identified as a need as were long term care facilities, e.g. long-term group homes for those with co-morbid acute brain injury and intellectual disability.

There are no clear pathways through the system; pathways are often determined by personal networks or relationships. The system was described as inflexible. There is no integrated system across the continuum of care or across government departments, e.g. justice, health, education and forensic. Telehealth needs to be improved (upskill GPs and local community workers, lack of technology, technology needs to be mobile).

Issues are statewide but there are regional differences, e.g. service challenges in the north west are related to reduced access to primary care, patients present late in their disease course and in crisis, many services ‘hold on’ to patients due to lack of confidence in other services and service gaps.

People want services that are family and carer friendly, that offer person-centred care, and have consumer involvement. People want to be seen by a compassionate, respectful, non-judgemental and highly skilled workforce. Carers require training and support, e.g. in respite, physical assistance, emotional support and financial assistance.
Workforce issues

Many workforce issues were described, including the attraction and retention of staff. Human resource processes were described as a contributor. Burnout was described as an issue. Some workforce groups were felt to be over-represented, e.g. social work, and staff skill sets were described as variable. Cultural and infrastructure issues stifled innovation in service delivery and performance management options were limited.

It was felt that there were a lack of bulk billing GPs in some areas, high turnover in rural areas, upskilling was needed in assessment, early intervention and prescriber training for drug and alcohol patients. Communication and partnerships with GPs are lacking. Psychiatrists need a public/private model which includes shared care.

It was felt that there are large gaps in non-government organisation infrastructure; they are fragmented with limited capacity, and not integrated into the service model. Some felt their role needs to be redefined and restructured.

The drug and alcohol sector is early in its development with deficits across the continuum of care. There is little early intervention or prevention for those with a dual diagnosis compounded by a lack of strategic direction and funding.

Suggested solutions

Case management needs to move towards an assertive outreach model and address issues beyond health. It needs to be clinician-led, with a change in scope of practice and focus.

The triage system needs to be improved with a single entry into the Tasmanian Department of Health and Human Services’ Mental Health Services and many pathways out. The role of CATT needs to be expanded to include assertive community treatment – an intensive and highly integrated approach for community mental health service delivery.

Primary care teams need to be developed with integrated, planned and shared-care pathways of care across public/private/non-government/primary care. Services should be co-located, e.g. integrate drug and alcohol services into mental health presentations in the hospital emergency department. ‘Consultation liaison’ models of care which specialise in the interface between general and specialist services are needed to facilitate access to specialist mental health services.

A statewide mental health service model is required, underpinned by clinical guidelines and protocols, memorandums of understanding for data and information sharing, and statewide clinical leadership. Key performance indicators need to focus on outcomes, and data collected needs to be relevant, with appropriate administrative support.

Patients need adequate (secure and stable) accommodation and long term accommodation options that incorporate care and treatment. Step-down and respite services are needed particularly in the north and north west, and step-up/step-down from forensic services to mental health services. A child and adolescent inpatient unit is required. Youth outreach and behavioural management services including day programs, step-up and step-down (transition) services. Adult Mental Health Services (AMHS) also require an increase in short term and long term beds (particularly for those with challenging behaviour).

A prevention agenda is needed with a lifespan approach to illness and a recovery focus. Services and facilities need to be fit-for-purpose and respond to patient need (e.g. not age, diagnosis). Services need to be easy to find, navigate, access and exit, with clear pathways.

It is necessary to create a more flexible approach that can better respond to clinical need (e.g. staffing, beds, and care packages). Staff need to be recruited to a service, not a position, and be able to rotate through positions. Middle management needs to be re-introduced, e.g. clinical nurse consultants and nurse managers. Consider peer support/peer workers.
References


54. “The University of Melbourne Centre for Mental Health: Evaluating the ATAPS component of the Better Outcomes in Mental Health Care Program (BOiMHC), Ten year consolidated ATAPS evaluation report. May 2013.”.


